STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

I. General Provisions

The North Dakota Department of Human Services ("NDDHS") elects to use the State plan amendment under section 1932(a)(1) and (2) of the Social Security Act ("Act"), permitting mandatory enrollment of eligible Medicaid enrollees into managed care entities ("MCE") on the basis of NDDHS's 1915(b) waiver of the Act.

The objective of the mandatory MCE enrollment is to assure adequate access to primary care by Medicaid enrollees; improve the quality of care received by enrollees; promote coordination and continuity of health care; reduce costs; and assist enrollees to use the health care system appropriately and effectively by preventing unnecessary utilization and reducing inappropriate utilization.

The basic concept is to allow Medicaid enrollees to select a MCE to provide, through an ongoing patient/physician relationship, primary care services and referral for all necessary specialty services. The MCE is responsible for monitoring the health care and utilization of non-emergency services. Neither emergency nor family planning services are restricted.

The MCE will assist the enrollee in gaining access to the health care system and will monitor on an ongoing basis the participant's condition, health care needs, and service delivery. The MCE will be responsible for locating, coordinating, and monitoring all primary care and other medical and rehabilitation services on behalf of enrollees enrolled in the MCE.

Enrollees will be restricted to receive services included under the managed care benefit package either from the chosen MCE or from another qualified provider to whom the participant was referred by the MCE. The enrollee's health care delivery will be managed by the MCE. The state plan's intent is to enhance existing provider-patient relationships and to establish a relationship where there has been none. It will reinforce continuity of care and efficient and effective service delivery.

A. Managed Care Entities
   1. Managed Care Organizations ("MCO")
      a) Health Maintenance Organization ("HMO") as set forth in North Dakota Century Code ch. 26.1-18.1-01

b) Provider Sponsored Organizations ("PSO") as set forth in North Dakota Century Code ch. 26.1-01-07.6 and North Dakota Administrative Code 45-06-13.
c) Health Insuring Organization ("HIO") means an entity that in exchange for capitation payments covers services for recipients through payments to, or arrangements with, providers.
d) MCOs will be contracted on a fully capitated, comprehensive risk basis.

2. Primary Care Case Managers ("PCCM") means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services. PCCMs are contracted to provide services through North Dakota Access and Care ("NoDAC"), the NDDHS administered PCCM program. Primary care case managers are:
   a) General practitioners, family practitioners, pediatricians, internists, obstetricians/gynecologists, or other physician specialty as approved by the NDDHS in either a solo or group practice, rural health clinics ("RHC"); all federally qualified health centers ("FQHC") within the state; or all Indian Health Service facilities ("IHS") within the state.
   b) PCCMs are reimbursed on a fee-for-service basis plus a management fee. The management fee is not paid to RHC, FQHC, or IHS by reason of the inclusion of the case management fee in the encounter fee paid to these facilities.

B. MCO contracts requirements
1. NDDHS will provide to the HCFA Regional Office MCO contracts for review and approval based on value and compliance with federal rules and regulations
2. All contracts with MCOs will comply with pertinent sections of 1932, 1903(m) and 1905(t) of the Act.
3. The MCO must assure the NDDHS that the MCO is an independent contractor providing services for the NDDHS and that neither the MCO nor any of the MCO's employees are employees of the NDDHS

C. Information requirements
1. NDDHS or each contracted MCO will furnish information to enrollees and potential enrollees.
2. By reason of the NDDHS administering the enrollment process through the county social service agencies, each county agency is able to assist enrollees and potential enrollees understand the managed care programs. In applicable counties where an MCO is available, the MCO staff will provide additional assistance to enrollees and potential enrollees to understand the requirements, benefits, and differences between plans.

3. Language
   a) Written materials, including vital documents, will be translated for eligible limited English proficiency ("LEP") language group that constitutes ten percent or 3,000, whichever is less, of enrollees to be served or likely to be directly affected by the enrollee's MCE
   b) Vital documents will be translated for eligible LEP language groups that do not fall within paragraph a) above, but constitute five percent or 1,000, whichever is less, of enrollees to be served or likely to be directly affected by the enrollee's MCE. Translation of other documents, if needed, can be provided orally
   c) A written notice of the right to receive competent oral translation of written materials in the primary language of the eligible LEP language group will be provided to enrollees that do not fall within a) and b) above, but are fewer than 100 persons in a language group to be served or likely to be directly affected by the enrollee's MCE
      1) This notice is available at the county social service agency, and will be provided upon initial medical assistance application and during continued contact with the enrollee.
   d) Statistics to measure the LEP language group will be obtained from a combination of the U.S. Census Bureau, Immigration and Naturalization Service, Lutheran Social Services, and county social service agencies.
   e) Oral interpretation services must be available from health care providers free of charge to enrollees of the MCO or PCCM program
      1) As guided by the Office of Civil Rights (OCR) of the U.S. Department of Health and Human Services' "Policy Guidance on the Title VI Prohibition against National Origin Discrimination As It Affects Persons with Limited English Proficiency"
   f) County social services agencies will notify enrollees and potential enrollees that oral interpretation and written information are available in languages other than English and how to access those services.
      1) This process is accomplished by a combination of county and state staff and private agreements with entities such as private individuals, Cultural Interpreter Services, Lutheran Social Services, and AT&T Language Line
4. Format
   All enrollment notices and informational materials must be provided in a manner and form which may be easily understood by enrollees and potential enrollees.
5. Information for potential MCO enrollees
   a) The county social service agencies or MCO will provide information to each potential enrollee residing in the MCO's service area.
      1) Information will be provided according to NDDHS's standard of promptness of 45 days. This timeframe is the maximum amount of time between the initial intake application process and eligibility authorization of the medical assistance case.

b) Required information
   1) Basic features of managed care
   2) Populations included and excluded from mandatory enrollment
   3) Populations free to choose between PCCM and MCO
   4) MCO responsibilities for coordination of care
   5) Benefits covered
   6) Cost sharing
   7) Service area
   8) Provider Directory available on-line at the NDDHS web site to allow county social service agencies to access and print for enrollees, or for enrollees to access directly. The directory will supply provider information such as name, specialty field, address, and if a physician's practice is closed.
   9) Benefits available under the State plan but not covered by MCO

6. Information for MCO enrollees
   After the MCO receives notice of the enrollee's enrollment, and once a year thereafter:
   a) Give each enrollee at least a 30 day written notice of any change in services, benefits or plan design
   b) Provide written notice of termination of a contracted provider
   c) Required information for enrollee handbook, at a minimum, should include the elements listed in Supplement 1.
7. MCO information upon request
   Upon request, the MCO shall provide enrollees or potential enrollees any of the following information upon request:
   a) MCOs and health care facilities' licensure, certification, and accreditation status.
   b) Information that includes, but is not limited to, education, licensure, and Board certification and recertification of health care professionals
   c) Information for accessing services, including factors such as physical accessibility and non-English languages spoken.
   d) A description of the procedures the MCO uses to control utilization of services and expenditures.
   e) A summary description of the methods of compensation for physicians.
   f) Information on the financial condition of the MCO, including the most recently audited information.
   g) Any information given to enrollees or potential enrollees
8. Information on PCCMs
   When potential enrollees are informed of the requirement to select a PCCM, the county social service agencies will provide information to each potential enrollee.
   a) Required information
      1) Basic features of managed care

2) Names of and non-English languages spoken by PCCMs and the locations at which they furnish services.
3) Any restrictions on the enrollee's choice of the listed PCCMs
4) How and where the enrollees may obtain benefits,
5) Cost-sharing
6) Available transportation

b) Additional information available upon request including grievance procedures available to enrollees, and how to obtain benefits during the appeals process.
c) The county social service agencies or MCO will provide information to each potential enrollee residing in the MCO's service area.
1) Information will be provided according to NDDHS's standard of promptness of 45 days. This timeframe is the maximum amount of time between the initial intake application process and eligibility authorization of the medical assistance case.

9. Comparative Information
NDDHS will make available a list identifying the MCEs available in the service area and information relating to:
a) benefits covered and cost sharing
b) service area
c) to the extent available, quality and performance indicators in a comparative or chart like format.

D. Provider discrimination prohibited
1. An MCO may not discriminate with respect to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.
2. If an MCO declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.
3. This does not restrict the MCO:
a) To contract with providers beyond the number necessary to meet the needs of its enrollees
b) From using different reimbursement amounts for different specialties or for different practitioners in the same specialty
c) From establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.

II. State Responsibilities

A. The NDDHS will adhere to State of North Dakota laws, codes, rules and regulations for the process of public notification to ensure public involvement in the Medicaid managed care program.

B. Enrollment
1. Eligible populations
With the exceptions of the excluded populations defined in B.2.b or as otherwise noted, the population identified below is mandatorily required to select a MCE
   a) Categorically needy
      1) Family Coverage Group (1931)
      2) Transitional (extended) Medicaid
   b) Optionally Categorically Needy
   c) Medically Needy (nonexempt)
      1) eligible for PCCM only
   d) Poverty Level
      1) Pregnant women
      2) Children to age 6
      3) Children ages 6 to 19
2. Excluded populations
The population identified below will be excluded from mandatory enrollment
   a) Enrollees under age 19 with special needs that are:
      1) Eligible for SSI
      2) Eligible under section 1902(e)(3) of the Act
      3) Eligible under a Maternal Child Health Services Block Grant
   b) All Dual Eligible Medicare enrollees
   c) Individuals residing in a nursing facility
   d) Individuals residing in an ICF/MR
   e) Enrollees receiving home and community based services
   f) Disabled enrollees
   g) Blind enrollees
   h) Aged enrollees
   i) Residents of the State Hospital
   j) Enrollees receiving foster care, IV-E and non-IV-E
   k) Enrollees receiving adoption assistance, IV-E and non-IV-E
   l) Enrollees receiving refugee assistance
   m) Enrollees having a retroactive eligibility period

3. In accordance with 1932(a)(1) and (2) of the Act, permitting mandatory enrollment of Medicaid enrollees into MCE, the NDDHS assures IHS facilities within the state will be PCCM. Thus allowing Native American Indians to be mandatory enrolled, and consequently the use of this state plan amendment.
4. Enrollment process
   The State administers the enrollment process through the county social service agency. At the time of application, the enrollee is informed of the need to select a MCE for each eligible member of the Medicaid unit. A continuous open enrollment period is conducted during which the MCE accepts all eligible enrollees in the order in which they apply without regard to health status of the enrollee or any other factor(s).
   a) The following process is in effect for enrollment in an MCE:
      County eligibility workers provide the enrollee with:
      1) a booklet explaining the program, its covered and non-covered services, out-of pocket costs, toll free and local telephone numbers to call for questions, and complaint procedures
      2) in counties where there is a choice between MCO(s) and PCCM, a comparative brochure is distributed
      3) a verbal explanation of the program
      4) a list of MCEs serving the enrollee's geographical area including the identity, locations and availability of health care providers that participate with the MCE
      5) county eligibility workers cannot influence the enrollee's decision on which MCE to select, only offer information
      6) the enrollee may notify the state by mail, telephone, or in person of their choice of MCE
      7) The MCE will be informed of the enrollee's enrollment:
         (a) if PCCM - by the remittance advice issued with the case management fee
         (b) if MCO - For each month of coverage throughout the term of the contract, the NDDHS shall transmit the MCO enrollment notification file to the MCO. Enrollment information will provide the MCO with identifying information about its Medicaid enrollees.
      8) Effective date of enrollment
         (a) PCCM - the date the enrollees selects the providers as the PCCM
         (b) MCO - the first day of the month following the month in which the person elects MCO enrollment. The enrollee will be exempt from any managed care requirements (open access to all services) for the time period between the date of MCO selection and effective date of enrollment.
      9) The enrollee will be issued an enrollment card

10) Enrollees will be advised which providers offer any special services such as different languages, interpretation services for the deaf, etc. offered by MCEs.

b) NDDHS has no automatic default enrollment process, but uses the process described in Supplement 8.

C. Individuals will have a choice of at least two MCE. In counties with only the NoDAC program, individuals will have a choice of at least two PCCMs. In counties where only one MCO is available, the state will offer NoDAC as the alternative MCE.

D. MCE requested disenrollment
1. The MCE may request disenrollment or exemption from enrollment for specific cases or persons where there is good cause. Good cause includes, but is not limited to the reasons in Supplement 3.
2. The MCE may not request disenrollment because of a change in the enrollee's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except where his or her continued enrollment in the MCE seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees)

E. Voluntary Disenrollment/Transfer
1. All enrollees shall have the right to request disenrollment/transfer from MCO or PCCM provider
2. The enrollee (or his or her representative) must submit an oral or written request to the county social service agency
3. The county eligibility worker and MCO must inform each enrollee of their right to request disenrollment/transfer at the time of enrollment.
4. Enrollees may request a change in their MCE:
   a) any time during the first ninety days;
   b) every six months; or
   c) if they have good cause.
   When a good cause request is made to change the MCE, the eligibility worker needs to determine if good cause exists and document the reason and decision. The worker determines the appropriate good cause change reason to use. Notification of denial of good cause must be provided to the enrollee. (See Supplement 4 for good cause reasons)
5. Voluntary disenrollment from a PCCM is effective the day the request is received.

6. Voluntary disenrollment from an MCO is effective the first day of the second month after the month in which the enrollee's request is received and processed (42 CFR 434.27).
7. Enrollees who request a change of their PCP six times within a twelve month period will be referred to the Surveillance Utilization Review System (SURS) staff to determine if over utilization patterns exist and could be subjected to the Lock-In Program
   a) The Lock-In Program is a process used to limit an enrollee's medical care and treatment to a single physician or other provider in order to prevent continued misutilization of services. Lock-in may be imposed by NDDHS on an enrollee who has misutilized services including, but not limited to, excessive services from more than one provider when there is little or no evidence of a medical need; drug acquisition in excess of medical need; and excessive utilization of emergency services. Lock-in may be imposed only on an individual enrollee and may not be imposed on an entire medical assistance unit. An enrollee may appeal the decision to impose lock-in.

F. Continued services to enrollees
   1. Medicaid enrollees whose MCE contract is terminated or who disenroll from an MCE for any reason other than ineligibility for Medicaid can access non-exempt Medicaid services once another MCE is selected.
   2. Exempt services such as emergency or family planning can be accessed at any time
   3. Inpatient hospital services provided during an entire inpatient hospital stay for an individual who enrolls in or disenrolls from the MCO's program while hospitalized will be paid by:
      a) The NDDHS if a Medicaid enrollee is admitted to an inpatient hospital prior to an effective enrollment date in the MCO's program and remains in the inpatient hospital setting on or after that effective enrollment date; and
      b) The MCO if a Medicaid enrollee in the MCO's program is admitted to an inpatient hospital prior to an effective disenrollment date and the enrollee remains in the inpatient hospital setting on or after the effective disenrollment date.

G. Monitoring procedures
   1. The MCO must submit quarterly and annual reports to monitor enrollment and disenrollment, grievances and appeals, and all other provisions of the contract, as appropriate.

III. Enrollee Rights and Protections

A. Enrollee rights.
   1. An enrollee of an MCE has the following rights:
      a) To receive information in accordance with Section I.C. Information Requirements
      b) To be treated with respect and with due consideration for his or her dignity and privacy
      c) To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand
      d) To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
   2. An enrollee of an MCO also has the following rights:
      a) To be furnished health care services in accordance access standards
      b) To obtain a second opinion from an appropriately qualified health care professional
      c) To request and receive a copy of his or her medical records, and to request that they be amended or corrected
   3. Enrollees are free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCE and its providers or the NDDHS treat the enrollee.

B. Provider-enrollee communications
   1. The MCE may not restrict or interfere with a health care provider's ability to advise enrollees about medically necessary treatment options. The MCE shall comply with any state or federal statute, rule, or regulation intended to limit or prevent restriction on, or interference with, communications between a health care provider and an enrollee concerning medically necessary treatment options.
   2. An MCE that violates the prohibition of provider-enrollee communication is subject to sanction.

C. Marketing activities
   1. Contract requirements
      a) The MCE must submit to the NDDHS for prior written approval a marketing plan, which will remain confidential, and all marketing materials and agrees to engage only in marketing activities which are preapproved

b) The NDDHS will review these materials and approve or disapprove them within 30 days.
c) The MCE must market to the entire service area under the contract
d) The MCE may not assert or imply that an enrollee will lose Medicaid benefits if he or she does not enroll in the MCE's plan
e) The MCE may not discriminate against any eligible individual on the basis of health status, past medical utilization, or need for future health care services
f) The MCE may not market or advertise a benefit of service unless it is clearly specified in the contract or unless it is a special program offered
g) Marketing materials cannot contain false and materially misleading information.
h) The MCE cannot offer other insurance products as inducement to enroll.
i) The MCE must not commit marketing fraud
j) The MCE must comply with federal requirements for provision of information including accurate oral and written information

2. In reviewing the marketing materials submitted by the MCE, the NDDHS will consult with and obtain approval from the Medical Care Advisory Committee

D. Liability for payment
MCOs must provide that its enrollees are not held liable for:
1. MCO debts, in the event of insolvency
2. Covered services provided to the enrollee, for which NDDHS does not pay the MCO
3. Covered services provided to the enrollee, for which NDDHS, or the MCO does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement
4. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the MCO provided the services directly.
a) Enrollees may only be held liable for the nominal established cost sharing amounts and not the balance of a claim that has been paid by the MCE.

E. Cost sharing
If the MCE imposes cost sharing on Medicaid enrollees, it must be in accordance with 42 CFR 447.50 through 447.60.

F. Emergency and post-stabilization services.
   1. Emergency medical condition is defined as, but limited to, a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence or immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant women the health of the woman or her unborn child, in serious jeopardy.
   2. Emergency services are covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services; and needed to evaluate or stabilize an emergency medical condition
   3. Post-stabilization care services means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the enrollee's condition.
   4. To enrollees and potential enrollees upon request, and to enrollees during enrollment and at least annually thereafter, the NDDHS and each MCO, must provide, in clear, accurate, and standardized form, information that describes or explains:
      a) The definitions of emergency medical condition, emergency services, and post-stabilization services
      b) Prior authorization is not required for emergency services
      c) The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent.
      d) The locations of any emergency settings and other locations at which MCE providers and hospitals furnish emergency services and post-stabilization services covered under a contract
      e) The enrollee has a right to use any hospital or other setting for emergency care
      f) The post-stabilization care services
   5. Coverage and payment
      a) MCO or the NDDHS through its PCCM program are responsible for coverage and payment of emergency services and post- stabilization care services.
      b) MCO or the NDDHS through its PCCM program must cover and pay for emergency services regardless of whether the provider furnishing the services has a contract with the MCO or PCCM

c) MCO or the NDDHS through its PCCM program may not deny payment for treatment obtained if an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition, or a representative of the MCO or PCCM instructs the enrollee to seek emergency services
d) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
e) The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCEs as responsible for coverage and payment.

G. Solvency standards
1. An MCO must meet the solvency standards set forth in the following and as listed in Supplement 7:
a) in North Dakota Century Code ch. 26.1-18.1 for HMOs
b) North Dakota Administrative Code 45-06-13 for PSOs
c) the appropriate rules and regulations that apply to an HIO's line of business as established and administered by the North Dakota Department of Insurance.
2. An MCO is exempt from these requirements if the MCO meets any of the following conditions:
a) Does not provide both inpatient hospital services and physician services
b) Is a public entity
c) Is (or is controlled by) one or more Federally qualified health centers and meets the solvency standards established by the State for those centers
d) Has its solvency guaranteed by the State

IV. QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

A. State quality strategies
   1. To assure quality of health care services in the managed care programs, MCEs are required to establish a program to promote quality and accessibility of care to enrollees
   2. Conduct periodic reviews to ensure compliance and evaluate the effectiveness of the strategy and update as appropriate
   3. Establish contractual requirements to meet certain NDDHS-specified standards
   4. Monitor and evaluate for compliance with standards
   5. Assure performance measures and levels consistent with section 1932(c)(1) of the Act.
   6. Arranging for external independent quality reviews (see Supplement 9 concerning external quality review and EQRO).

B. Availability of services and capacity
   1. Assurance that all covered services are available, accessible and that the MCO has the network capacity to serve the expected enrollees in its service area.
   2. Direct access to a women's health specialist to provide routine and preventive health care services
   3. Second opinion must be available at no cost to the enrollee
   4. If an MCO seeks an expansion of its service area, the MCO must demonstrate sufficient numbers and types of providers to meet the additional volume and types of services the added enrollees may require.
   5. MCO must coordinate with out-of-network providers concerning payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.
   6. Each MCE must meet standards for timely access to care and services
      a) Standard for the time period between scheduling a medical appointment and the appointment date, for non-emergent or non-urgent care, is 75% within 1 week, 90% within 2 weeks.
      b) See Supplement 10 concerning statistics
   7. Provider services must be available 24 hours a day, 7 days a week, when medically necessary

C. Coordination and continuity of care
   1. The NDDHS, through its monthly electronic transmission of enrollment to MCOs, provides ages and identifies pregnant women.
   2. Each MCO must make a best effort attempt to perform an initial screening and assessment for all enrollees within 90 days from the date of enrollment. For any enrollee the screening identifies as being pregnant or having special health care needs, a comprehensive health assessment should be performed no later than 30 days from the date of identification.

3. For pregnant women and for enrollees determined to have special health care needs, each MCO must implement an appropriate treatment plan
4. Each MCO must implement a coordination program that meets NDDHS requirements and:
   a) Ensures that each enrollee has an ongoing source of primary care
   b) Ensure referrals for medically necessary care
   c) Ensure provision of care in emergency situations, including an education process
   d) Has in effect procedures to address factors (such as a lack of transportation) that may hinder enrollee compliance with medical treatments
   e) Ensures that its providers have the information necessary for effective and continuous patient care and quality improvement, consistent with the confidentiality and accuracy requirements

D. Coverage and authorization of services.
1. Each MCO must make available the services it is required to offer at least in the amount, duration, and scope that are specified by the NDDHS and are sufficient to reasonably be expected to achieve the purpose for which the services are furnished.
2. Each MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition
3. Each MCO may place appropriate limits on a service on the basis of criteria such as medical necessity (as defined by NDDHS); or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose
4. Each MCO must notify the requesting provider, and give the enrollee written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
   a) Timeframe for standard authorization decisions may not exceed 10 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days
   b) Timeframe for expedited authorization decisions may not exceed 72 hours after receipt of the request, with a possible extension of up to 14 additional calendar days.
5. Utilization management activities should not be structured so as to provide incentives to deny, limit, or discontinue medically necessary services to any enrollee

E. Credentialing and recredentialing
The MCO shall establish and verify minimum credentialing and recredentialing criteria for all professional participating providers

F. Confidentiality and accuracy of enrollee records
Each MCO must establish and implement procedures to:
1. Maintain the records and information in a timely and accurate manner
2. Protect the confidentiality of any material and information concerning an enrollee, in accordance with relevant laws, regulations, and policies, including NDDHS Manual Chapter 110-01, Confidentiality, and 42 CFR 431 subpart F.
3. Ensure that each enrollee may request and receive a copy of records and information pertaining to him or her and request that they be amended or corrected in accordance with the Health Insurance Portability and Accountability Act of 1996.
4. Ensure that each enrollee may request and receive information on how the MCO uses and discloses information that identifies the enrollee.

G. Subcontracting
1. The MCO shall have no right to and shall not assign, transfer, delegate, or subcontract the contract or any right or duty arising under the contract without the written approval of the NDDHS
2. Any subcontracting arrangements must comply with 42 CFR 434.6(b) and (c).

H. Performance Improvement
1. Each MCO must conduct performance improvement projects that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.
   a) Performance improvement projects are MCO initiatives that focus on clinical and non- clinical areas, and that involve the following:
      1) Measurement of performance using objective quality indicators.
      2) Implementation of system interventions to achieve improvement in quality.
      3) Evaluation of the effectiveness of the interventions.
      4) Planning and initiation of activities for increasing or sustaining improvement.
   b) Each project must represent the entire Medicaid enrollee population
   c) Each MCO initiate each year one or more projects among the required clinical and non-clinical areas
   d) Clinical areas include:
      1) Prevention and care of acute and chronic conditions;
      2) High-volume services;
      3) High-risk services; and
      4) Continuity and coordination of care.

e) Non-clinical areas include:
   1) Grievances and appeals;
   2) Access to, and availability of, services; and
   3) Cultural competence.

f) In addition to requiring each MCO to initiate its own performance improvement projects, the NDDHS may require that an MCO to conduct particular performance improvement projects on a topic specified by the NDDHS and participate annually in at least one Statewide performance improvement project.

2. The NDDHS must review, at least annually, the impact and effectiveness of each MCO's quality assessment and performance improvement program.

I. Health information systems
The NDDHS must receive assurance that each MCO maintains a health information system that collects, analyzes, integrates, and reports data and makes all collected data available to the NDDHS and upon request to HCFA

V. GRIEVANCES AND APPEALS

A. Enrollee may present grievances to the MCO or the NDDHS, regarding any aspect of service delivery provided or paid for by the MCO.

B. Each MCO must have a system that includes a grievance process, an appeal process, and access to the NDDHS's fair hearing system.

C. The MCO shall acknowledge receipt of a grievance if orally (to be followed in writing) or in writing and must notify the enrollee that he or she has 30 days from the date of an adverse decision or 15 days from the issuance of a final decision on a grievance, whichever is later, to appeal to the NDDHS by requesting a fair hearing.

If the MCO or any of its participating providers authorizes a course of treatment, but subsequently decides to terminate, suspend, or reduce the course of treatment, and the decision is not mutually agreeable to the enrollee, the MCO or its participating provider must take the following actions:

1. Mail a written notice to the enrollee 10 days prior to termination, suspension, or reduction of the course of treatment, unless the determination is made less than 10 days before the conclusion of the course of treatment, in which case notice must be sent as soon as possible. Such notice shall inform the enrollee of the action being taken, the reason for the action, the specific regulations that support the action, and the enrollee's right to grieve the action; and
2. Should the enrollee file a grievance prior to the date the services are suspended, terminated, or reduced, the course of treatment shall be maintained until the grievance is resolved, an appeal to the NDDHS is resolved, or the course of treatment is concluded, whichever is earlier.
3. Nothing in this section prevents the MCO or the NDDHS from requiring prior authorization or that care be medically necessary; or from setting uniform limits on services as long as those limits are not more restrictive than Medicaid's limits. This section does not apply to courses of treatment initiated prior to an enrollee becoming an enrollee of the MCO.

D. The MCO shall inform applicants and enrollees of services provided through this contract of any right there may be to present grievances to the MCO and the NDDHS, upon enrollment, and annually thereafter.

E. The NDDHS must approve the MCO's grievance procedure in writing.

F. The MCO grievance procedure should include, but is not limited to the elements listed in Supplement 5.

G. In situations requiring urgent care or emergency care the NDDHS will require the MCO to expedite resolution of disputes, appeals, and grievances.
   1. Expedited decision for services that meet the definition of emergency medical conditions must be communicated to the enrollee as expeditiously as possible, but no later than 24 hours following receipt of an expedited review.
   2. Expedited decision for immediately and urgently needed services that do not meet the definition of emergency medical condition must be communicated to the enrollee as expeditiously as possible, but no later than 24 hours following receipt of an expedited review.
   3. Expedited decision for services that require prior authorization or for a requested inpatient stay or service(s) must be communicated to the enrollee as expeditiously as possible, but no later than 72 hours following receipt of an expedited review.

H. The MCO shall submit to the NDDHS a quarterly report summarizing each grievance handled during the quarter.

I. A final grievance decision by the MCO may be appealed by the enrollee to the NDDHS. The NDDHS shall notify the MCO of an enrollee's request for NDDHS review. The MCO shall participate in NDDHS reviews. The NDDHS shall review such appeals and reserves the right to affirm, modify, or reject the final grievance decision of the MCO at any time after an appeal is filed by the enrollee. The MCO shall abide by the decision of the NDDHS. Any decision made by the NDDHS pursuant to such a review shall be subject to review under North Dakota Century Code ch. 28-32.

VI. Certifications and Program Integrity Provisions

As a condition for contracting and for receiving payment under the Medicaid managed care program, an MCO and its subcontractors must comply with the following certification and program integrity requirements:

A. If payments to the MCO are based on data submitted by the MCO, the MCO must certify to the accuracy, completeness and truthfulness of data.

B. Regardless of whether payment is based on data, each MCO must concurrently certify that it is in substantial compliance with its contract.

C. The MCO must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.

VII. Sanctions

A. In addition to exercising termination of provisions, the NDDHS may impose sanctions on the MCO including but not limited to civil money penalties, appointment of temporary management, granting enrollees the right to terminate enrollment without cause, suspension of all new enrollment, or suspension of payment for enrollees enrolled after the effective date of the sanction.

B. The NDDHS determination to impose a sanction may be based on findings from onsite survey, enrollee or other complaints, financial status, any other source, or acts or fails to act as follows:
   1. Fails to provide medically necessary services that the MCO is required to provide, under law or under its contract with the NDDHS
   2. Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
   3. Acts to discriminate among enrollees on the basis of their health status or need for health care services.
   4. Misrepresents or falsifies information that it furnishes to HCFA or to the NDDHS
   5. Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
   6. Fails to comply with the requirements for physician incentive plans
   7. An MCO or a PCCM distributes directly or indirectly, marketing materials that have not been approved by the NDDHS or that contain false or misleading information.
   8. An MCO violates any of the requirements in section 1903(m) of the Act and implementing regulations, or an MCO or a PCCM violates any of the requirements of section 1932 of the Act and implementing regulations.

C. The NDDHS has the authority to terminate an MCO or PCCM contract and enroll that entity's enrollees in other MCOs or PCCMs, or provide their Medicaid benefits through other options included in the State plan, if the State determines that the MCO or PCCM has failed to carry out the substantive terms of its contract or has failed to meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Act.

D. Notice of sanction and pre-termination hearing.
   1. Before imposing any of the alternative sanctions, the NDDHS must give the MCO timely written notice that explains the basis and nature of the sanction, and any other due process protections that the State elects to provide.

2. Before terminating the MCO or PCCM contract, the NDDHS must provide the MCO or PCCM a predetermination hearing. The NDDHS must:
   a) Give the MCO or PCCM written notice of its intent to terminate, the reason for termination, and the time and place of the hearing;
   b) After the hearing, give the MCO or PCCM written notice of the decision affirming or reversing the proposed termination of the contract and, for an affirming decision, the effective date of termination;
   c) For an affirming decision, give enrollees of the MCO or PCCM notice of the termination and information, and their options for receiving Medicaid services following the effective date of termination.

VIII. Conditions for Federal Financial Participation

A. FFP is available under an MCO contract for the periods during which the MCO and the NDDHS are:
   1. in compliance with the contract in effect; and
   2. the MCO and its subcontractors are in compliance with the physician incentive plan requirements of 42 CFR 417.479 .and 42 CFR 434.70(a)(3)

B. FFP is available under a comprehensive risk contract upon prior approval by the HCFA Regional Office

C. Excluded from receiving FFP
   1. An entity being controlled by a sanctioned individual
   2. An entity that has a contractual relationship with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act
   3. An entity that employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with any individual or entity excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act or any entity that would provide those services through an excluded individual or entity.

D. Limit on payments in excess of capitation rates
   FFP is not available for payments pursuant to risk corridors or incentive arrangements that exceed 105 percent of that portion of the aggregate amount approved capitation payments attributable to the enrollees or services covered by the risk corridor or incentive management.

IX. Payment for Services

The MCE must require providers to submit all claims no later than 12 months from the date of service. The MCE must pay 90 percent of all clean claims from practitioners within 30 days of the date of receipt. The MCE must pay 99 percent of all clean claims from practitioners within 90 days of the date of receipt. The MCO must pay all other claims, except claims for excluded or unauthorized services, within 12 months of the date of receipt.